Program Review: HIV/AIDS Care and Prevention Services

Prepared for the Committee on Legislative Research
by the Oversight Division

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February, 1998

Members of the General Assembly:

As authorized by Chapter 208.325 (20) RSMo, the Joint Committee on Legislative Research adopted a resolution in May, 1997, directing the Oversight Division to perform an evaluation of the Department of Health - HIV/AIDS Care and Prevention Services which included the examination of records and procedures in the Department of Health to determine and evaluate program performance in accordance with program objectives, responsibilities, and duties as set forth by statute or regulation.

The accompanying report includes Oversight's comments on internal controls, compliance with legal requirements, management practices, program performance and related areas. We hope this information is helpful and can be used in a constructive manner for the betterment of the state program to which it relates.

Respectfully,

Senator Harry Wiggins, Chairman

Representative Larry Thomason, Vice Chairman

EXECUTIVE SUMMARY

PROGRAM REVIEW: BUREAU OF HIV/AIDS CARE AND PREVENTION

Summary of Oversight Divisions Findings

The Department of Health's Bureau of HIV/AIDS Care and Prevention manages the Ryan White and other statewide programs for people living with HIV/AIDS. The Bureau is responsible for fiscal management and reporting, contract monitoring, quality assurance and evaluation, and planning and program development for the following programs: Ryan White Title II, AIDS Drug Assistance Program, Special Projects of National Significance, Housing Opportunities for Persons with Aids, Medicaid AIDS Waiver, and Service Coordination Program. Based on SFY98 budget information, the Bureau employs 38 FTE with an annual administrative and program budget of $8,054,287. The program was reorganized administratively within the Department of Health in February, 1996 and again in May, 1997. Substantial outsourcing of functions within the Bureau occurred during this time period

Has the Department of Health efficiently administered the programs under the responsibility of the Bureau of HIV/AIDS Care and Prevention? Failure of the Department to monitor benefit administration contracts, after outsourcing the function to a private company, resulted in thousands of dollars in overpayments to the contractor. Upon bringing the situation to the attention of both the Department and the contractor, the contractor immediately issued credit memorandums to the Department for over $64,000 with the promise of yet more credits to follow. This contractor was issued an advance payment by the DOH of $379,655 prior to the awarding of a contract, even though the finalized contract provided only for cost reimbursements. After the Department had outsourced the benefit administration function (payment of bills), no corresponding staff reduction in the Department was made. The outsourcing of this function, with no corresponding reduction of in-house administrative costs, has resulted in the addition of approximately $350,000 annually in administrative costs to the program. In addition to outsourcing the benefit administration, the Department also chose to outsource the service coordination activities. This outsourcing was accomplished at cost plus 5% with no established guidelines regarding expected caseloads. In another area, the Department apparently had not aggressively pursued pharmaceutical rebates from drug manufacturers which could have made thousands of additional dollars available for ADAP program expenditures. It appeared that the Department had only reaped the benefits from the rebate program during the period reviewed from two companies who pursued establishing rebate agreements. Oversight also noted situations in which the Department did not require competitive bidding of subcontractors and did not build in ample lead time on all contracting activities.

Were program functions effectively carried out by the Department of Health? Oversight interviewed bureau staff and service coordinators. It appears that services to the HIV/AIDS clients statewide may be inconsistent because of a lack of understanding regarding responsibilities of service coordinators. The service coordinators had different and varying ideas of what their responsibilities were to clients. Examples of differences included checking Medicaid eligibility, verifying income, establishing residency, authorizing 24 hour care, conducting outreach, determining annual caps and funding sources, and accessing all available services. The service coordination manuals they were working from were inconsistent. This problem was identified by internal department staff as early as 1995. The Department has also not monitored its professional services contracts on a regular basis to ensure provision of services to clients and to verify existence and/or appropriateness of program expenditures. Apparently, the Department made some informal "fact finding" visits during 1996, but no formal monitoring was done of Ryan White Title II expenditures. Department personnel indicated they completed desk audits for 1995, but a review of the files only revealed two such audits. Failure to properly monitor outsourcing could put the program at risk of not meeting its objectives. Oversight recommends the Department monitor its professional services contracts in accordance with its own policies and procedures already in place.

This review includes detailed findings and recommendations for suggested legislative or program changes. The Department of Health's official responses to the findings and recommendations are incorporated into the report. Our review was conducted in accordance with government auditing standards. We did not examine departmental financial statements and do not express an opinion on them.

Jeanne A. Jarrett, CPA, CGFM
Director, Oversight Division

Introduction

The Joint Committee on Legislative Research directed the Oversight Division to conduct a program review of the Department of Health's HIV/AIDS program. The purpose of the review was to provide the General Assembly with information as to whether resources are being used efficiently and effectively, administered as authorized or required by law and conform with legislative intent.

Background

The Department of Health's Bureau of HIV/AIDS Care manages Ryan White and other statewide programs for people living with HIV/AIDS. The Bureau of AIDS Prevention administered Ryan White Title II funds for the first four years of the program. Starting with Ryan White Program Year 1995 (April 1, 1995) and until February of 1996 (ten months of Ryan White Program Year 1995), the Office of HIV/AIDS Care within the Bureau of Special Health Care Needs managed the programs. The Office was elevated to Bureau status in February of 1996. The Bureau was transferred from the Division of Maternal, Child and Family Health to the Division of Environmental and Communicable Disease Prevention beginning in May of 1997.

The Bureau of HIV/AIDS Care is responsible for fiscal management and reporting, contract monitoring, quality assurance and evaluation, and planning and program development for the following programs:

- Ryan White Title II
- AIDS Drug Assistance Program (ADAP)
- Special Projects of National Significance
- Housing Opportunities for Persons with Aids (HOPWA)
- Medicaid AIDS Waiver
- Service Coordination Program

In 1990, Congress passed and President Bush approved, the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act of 1990. The CARE Act provides funding to state and local governments "...to improve the availability and quality of community-based outpatient primary health care

and support services for individuals and families with HIV disease" according to the Health Resources Service Administration. The CARE Act was reauthorized, with amendments, in 1996.

Title II of the CARE Act provides funds for states which may choose to support services to provide: 1) a comprehensive continuum of care to persons living with HIV; 2) home- and community-based services; 3) continuation of health-insurance coverage for persons with HIV; and/or 4) treatment and drugs that extend life or preserve health of persons with HIV. Prior to the 1996 Care Act Amendments, states with at least 1% of AIDS cases were required to spend at least 50% of Title II funds to operate consortia. (NOTE: Missouri matches 50% of its federal grant.)

The AIDS Drug Assistance Program (ADAP) is a Title II supplemental program which makes funds available (if appropriated) for provision of treatment (medications) to persons with AIDS.

Special Projects of National Significance is a Title II program which provides competitive grants for special projects including the development and assessment of innovative service delivery models. Among the models are those which address the needs of special populations and ensure ongoing availability of services.

The Housing Opportunities for Persons with Aids (HOPWA) program provides housing assistance and support for low income persons with HIV/AIDS and their families. Competitive HOPWA grants may be used for an array of housing, social services and program planning and development costs. Missouri does not qualify for a formula grant. HOPWA grants may be spent over a three-year period. Funds may be used for, among other things, acquisition, rehabilitation or new construction of housing units; operation of facilities and community residences; rental assistance and short-term payments to prevent homelessness; health care and mental health services; chemical dependency treatment; nutritional services; case management; and assistance with daily living.

The Medicaid AIDS waiver allows Missouri to pay for home health care for persons with AIDS as an alternative to otherwise more expensive institutional care.

Case management is a range of client-centered services including health care, psychosocial and other services to insure timely, coordinated and appropriate levels of care and support services and to provide on-going assessment of the client's needs. The Department of Health is currently in the process of contracting all "front line" case management.

The Department of Health was responsible for **Benefit Administration** for Ryan White services until the beginning of Program Year 1996. In April 1996, the Department entered into four contracts for benefit administration. The benefit administrators for Program Year 1996 were the St. Louis City Department of Health for the St. Louis Region, the Kansas City Department of Health for the Kansas City Region, Missouri Western State College for the Northwest Region, and Healthcare Strategic Initiatives for the other three regions.

The Department entered into a statewide contract with Healthcare Strategic Initiatives for benefit administration for the entire state for Program Year 1997 (April 1, 1997 through March 30, 1998).

Objectives

The primary focus of the review was to provide the General Assembly with information regarding the effectiveness and efficiency with which the Department of Health carries out its administrative duties and oversight of the HIV/AIDS program. Specifically, Oversight Division staff concentrated on four primary objectives:

To determine if DOH is meeting its regulatory and contractual obligations relating to the administration/oversight of the Bureau of HIV/AIDS Care and Prevention.

To determine if DOH is using its resources efficiently to carry out duties related to the HIV/AIDS program.

To determine the effectiveness of the HIV/AIDS program.

To assess the adequacy of the Request for Proposal (RFP) process in awarding contracts to benefit administrators in program year 97.

Scope

The scope of the review focused on the operations of the HIV/AIDS program from April 1996 through November 1997 (Program Years 1996 and 1997). Expenditures of Ryan White Title II funds, matching General Revenue and HOPWA funds were examined. The main areas considered were DOH monitoring of contracts and expenditures, outsourcing benefit administrator and service coordinator functions and maximizing available funding to serve HIV/AIDS clients. The scope was limited due to DOH's concerns regarding confidentiality of records. Oversight staff was not permitted to access or review client files and therefore, could not examine source documentation to verify appropriateness and/or existence of some expenditures.

Methodology

The Oversight Division conducted the review in accordance with Government Auditing Standards issued by the Comptroller General of the United States as those standards relate to program and performance audits. The methodology used by the Oversight Division included evaluation of management controls to the extent necessary to fulfill our review objectives. A primary method used to measure objectives was conducting interviews with agency personnel. In addition, staff performed on-site testing of controls and procedures. Also, staff visited various DOH facilities, as well as visited with some contractors and subcontractors. Finally, contracts were reviewed for compliance with applicable rules, regulations and policies.

Findings
Recommendations
Agency Responses

FINDING #1:	**Failure of the Department of Health (DOH) to perform administrative duties resulted in more than $64,000 in program overpayments going undetected.**

The current contract with the benefit administrator, Healthcare Strategic Initiatives, L.L.C., (HSI) provides that DOH will pay for services and/or medications after HSI has paid the vendors (cost reimbursement). However, HSI bills and receives payment from DOH for expenses as authorized, regardless of whether or not the expenses have been incurred or paid by HSI. After Oversight discovered this discrepancy, HSI admitted to overcharging DOH in excess of $64,000 during PY 1996 and an unknown amount from April 1, 1997 to the current date. In effect, the state has reimbursed HSI for items which HSI has either never paid or has received reimbursement from other sources.

Rule 19 CSR 40-13.020(1)(A) requires that the "department shall be billed only after all third party sources have been eliminated as payors." Furthermore, Section 3.6 of the Invitation for Bid (IFB# 7036) requires HSI to "submit timely invoices to the Department that meet the requirements of this contract for the reimbursement of program expenditures" (emphasis added). DOH's Division of Administration also confirmed that the contract with HSI is considered a cost reimbursement contract.

DOH has apparently paid HSI for services that were either never delivered or were paid from other sources, such as Medicaid or private insurance, resulting in HSI receiving double payment for some services. DOH gave HSI an advance in the amount of 10% of the contractual amount, apparently to offset the lag time between HSI's payment to the provider for services/products received and DOH's reimbursement of those expenditures.

Upon Oversight's discovery that DOH makes payments to HSI prior to HSI's payment of expenses, HSI issued two credit memorandums to DOH. HSI issued a credit memorandum in the amount of $32,973 on October 19,

1997; and another credit memorandum in the amount of $31,244 on October 31, 1997. It should be noted that HSI initially told Oversight they were issuing credits on a monthly basis. Upon further research, Oversight confirmed that no credits had been issued. HSI later admitted that no credits had been issued. DOH personnel confirmed they are unable to determine the extent of overpayments and are solely relying on HSI to advise them of overpayments. Since Oversight staff was denied access to client records based on confidentiality concerns, the extent of the contract violations could not be verified. HSI has reported the total overpayments for the program year ending March 31, 1997 to be $64,217. HSI has confirmed that there are credits due to DOH for overpayments during PY 97; however, as of January 15, 1998, HSI had not determined the amount due nor issued a credit memorandum to DOH.

RECOMMENDATION TO FINDING #I

Oversight recommends that the Department of Health (DOH) consider canceling the contract with HSI due to failure by HSI to comply with contract requirements. Additionally, independent auditors with access to client files should be asked to examine the records for the contract periods to determine the exact amounts of overpayments to HSI for PY 96 and to date for PY 97. Recoupment should be sought on any remaining overpayments.

Agency Response to Finding #I

Department of Health:

There was no overpayment of any funds and no failure to perform administrative duties. The $64,000 referred to in the findings reflects routine Medicaid credits and a system intentionally designed to maintain fiscal accountability while maximizing available medication funding sources for the client as follows:

As was explained to Oversight staff, a person can become Medicaid eligible as much as three months retroactively. For example, a client can receive medicines on January 1st and not be Medicaid eligible at that time; HSI would incur the cost of the medicine and pay the pharmacy. On March 31, the same client could become eligible for Medicaid retroactively back to January 1st. At that time, HSI would notify the pharmacy to bill Medicaid for those medicines and credit HSI on their next invoice. HSI would then include those funds that were recouped as a credit on the next HSI invoice

to DOH. In this instance, HSI would have incurred a legitimate expense in January that becomes a legitimate credit in March.

Section 3.5 of the scope of work requires HSI to pay legitimate claims from providers in a timely fashion. Section 5.4.3 of the scope of work also states that DOH will not reimburse HSI for any services invoiced more than 60 days from the actual date of service. Therefore, in the example above HSI could not have waited until March 31st to pay for or invoice DOH for the January 1st medicines.

HSI has a shorter turn around time in paying their bills than DOH does. For example, the pharmacists bills weekly and HSI pays within 7 days; utilities and rent are paid within 4 days. HSI then bills DOH at the end of the month based on authorizations that they have issued. By the time HSI bills DOH, they have paid the majority of the authorizations.

Bureau management has improved this process by negotiating an agreement with HSI that credits be issued on an on-going monthly basis as they become available. This finding also alleges that payments were made to HSI for services that were not rendered. At no time did DOH make payments for services that were not delivered.

Oversight Division's Comment to Finding #1

No credits from HSI had been issued to DOH prior to Oversight's inquiry. Furthermore, not all credits issued by HSI related to Medicaid, as alluded to by DOH in their response. The $64,000 in credit memorandums described above dated October, 1997, relate to overpayments during Program Year 96 only.

FINDING #2:	**The Department of Health (DOH) outsourced administrative duties without a corresponding staff reduction, resulting in additional administrative costs of $350,000 annually.**

The Department of Health (DOH), Bureau of HIV/AIDS Care did not conduct a comprehensive study or evaluation to determine whether contracting out the benefit administrator functions would be more feasible than performing these functions internally. Beginning in 1995, DOH outsourced the benefit administrator functions for the Ryan White Title II and HOPWA programs.

The Ryan White Title II benefit administrator Invitation For Bid for Program Year 1997 (PY 97) was based on DOH's assumption that this function required 5.5 FTE; however, DOH did not reduce the number of in-house FTE employed by their Bureau to reflect this decrease in workload. Furthermore, Healthcare Strategic Initiatives, L.L.C. (HSI), the current benefit administrator for the Ryan White Title II program, appears to be performing these functions with significantly less FTE than the 5.5 outlined in the Invitation For Bid. If the benefit administrator functions are contracted out, then it would appear that the DOH should have reduced their in-house FTE to support the outsourcing decision. The number of FTE required for this function should be determined. The outsourcing of the benefit administrator function for the Ryan White Title II benefit administrator duties has resulted in additional costs to the programs of approximately $350,000 annually. Specifically, DOH spent $226,922 during PY 96 and has contracted to spend $307,789 during PY 97 for the Ryan White Title II benefit administrator duties. Furthermore, DOH has contracted to spend $41,052 during PY 97 for the HOPWA benefit administrator duties and spent significantly more for this function during PY 96.

Although the total number of FTE employed by the DOH, Bureau of HIV/AIDS Care has decreased due to outsourcing of service coordination, overall, the number of administrative and support staff employed by the Bureau has not decreased. Shifting a major administrative function to a private contractor would likely lessen the administrative duties of the Bureau.

RECOMMENDATION TO FINDING #2

Oversight recommends the Legislature consider either reducing the Department of Health, Bureau of HIV/AIDS Care core budget by $350,000 annually or shifting costs from administrative to program related costs, absent justification to the contrary.

Agency Response to Finding #2

Department of Health:

This finding is incorrect, unsubstantiated and contradictory to other Oversight findings in this report as follows:

a. *The $350,000 referred to in this finding is the 8% administration cost charged by the statewide benefits administrator. The Department of Health is committed to being fiscally responsible in the administration of this program and the statewide benefits administrator process has helped to assure this accountability through a daily accounting of funds, a coordination of all funding sources, quicker turn around for billing, immediate client service delivery, assuring that funds are available for all authorized client services before services are provided.*

b. *The Department's legacy benefit administration data system, MOCARES, did not possess the financial features and fiscal controls necessary to administer the complexities of this program. Therefore, experience has shown us that privatization of the benefits administration was far more timely than developing a new system. Additionally, procuring the services of a vendor with an existing data system was more cost effective than expending dollars to develop and maintain a system of our own.*

c. *As the report states in finding #13, Bureau of HIV/AIDS Care and Prevention Services is already in need of additional staff to more effectively administer HIV/AIDS care programs. This recommendation to decrease administrative funding by nearly one-third is contradictory to finding #13.*

Oversight Division's Comment to Finding #2

This finding is not contradictory to Oversight's Finding #13, as Oversight is not recommending DOH hire additional staff. Oversight is merely suggesting that DOH redirect the efforts of its current staff.

FINDING #3:	**The outsourcing of service coordination activities has resulted in additional costs of over $52,000 to the Department of Health (DOH), Bureau of HIV/AIDS Care.**

In an effort to reduce payroll costs and to shift responsibility for this function, the Bureau of HIV/AIDS Care outsourced the service coordination function. However, costs associated with service coordination activities have not been

reduced and, in fact, have increased. With each position outsourced, the Bureau has contracted to pay out an equivalent amount for salary, fringe benefits, and travel expenses. In addition, the Bureau has contracted to pay an additional five percent (5%) over and above this amount for "other indirect/operating costs." Therefore, this outsourcing effort has actually cost the Bureau an additional $52,848 over costs incurred when these employees were employed directly by the Bureau.

Furthermore, some direct control has been lost in the outsourcing effort. The Bureau does not have caseload standards in place to determine the number of service coordinators needed. We observed one service coordination contract in which the Bureau was paying $19,913 per year for a 0.5 FTE. This 0.5 FTE serves an eight-county area with 135 reported HIV/AIDS cases. However, only 15 to 17 clients are receiving service coordination and the coordinator reported that these clients were in good health and require little assistance.

Even though the DOH has outsourced most service coordination efforts, the DOH is still ultimately responsible and should establish a system which assigns acuity levels to clients based on the level of care required in order to establish expected caseloads. Currently, the Bureau is unable to confirm the actual amount of time being expended by service coordinators. When caseloads fall below a certain level, then the funding provided for service coordinators should be adjusted accordingly. The outsourcing of service coordination efforts should be a cost-saving decision, rather than a decision that increases the expenditures associated with this effort. It seems counter-productive for the Bureau to lose control over this function, while increasing expenditures related to the effort.

RECOMMENDATION TO FINDING #3

To help offset or reduce the increased cost of outsourcing the service coordination functions, Oversight recommends the Department of Health, Bureau of HIV/AIDS Care establish guidelines relating to the expected client caseloads for service coordinators and adjust service coordinator staffing/contracting costs accordingly.

Agency Response to Finding #3

Department of Health:

DOH disagrees with this finding. The $52,000 referred to in this finding reflects the five percent administration cost of the service coordination contracts. The following analysis shows an overall savings to the state by outsourcing HIV/AIDS Service Coordination.

Total Annual Salaries of DOH Staff to be Outsourced	*$437,676 (Bureau budget)*
+26.5% Fringe Benefits	*$109,419 (OA Budget)*
+35.1% Indirect Costs	*$192,303 (DOH Budget)*
Total Annual Cost to State	*$739,125*
Total Annual Cost of Resulting Contracts	*$438,086*
Net Annual Savings to State	*$301,039*

a. *The outsourcing of service coordination was never "an effort to reduce payroll costs and to shift responsibility for this function". As was explained to Oversight staff, the outsourcing of service coordination was the result of three things: (1) an effort to streamline a multi-layered service coordination system to make it less confusing and complicated for clients; (2) a desire to put local service coordination in the hands of local health agencies and local providers; and (3) the legislative directive to do so by shifting funds from personal services to expense and equipment.*

b. *The program review attempts to substantiate this finding by stating that the Bureau has no caseload standards in place. In fact, the HIV/AIDS service coordination contracts state that each agency should average no more than fifty clients for each full-time service coordinator. Additionally, the Bureau already has in place a system of assigning acuity levels to clients in order to determine anticipated case loads, as the report recommends. These figure are only anticipated levels to determine funding. What the Bureau is "buying" with these contracts is the availability of service coordination to all HIV+ persons in the area who request it, as well as outreach activities to find and educate new clients. These contracts are not*

designed to, nor do we believe it is in the best interest of the clients to, pay for service coordination as a fee-for-service, based solely on the clients, visits, or referrals actually processed.

Oversight Division's Comment to Finding #3

Information provided indicated total contract costs for service coordination were over $1 million. DOH is citing information for positions contracted out in FY 98. The finding was based on a cumulative effect of outsourcing all service coordination activities. Also, Oversight has seen no evidence that "indirect costs" for outsourced positions were saved or otherwise lapsed.

FINDING #4:	**During Fiscal Years 1996 and 1997, over $130,000 of Medicaid reimbursement payments to the Bureau of HIV/AIDS Care were deposited directly into the divisional account of the Maternal, Child and Family Health Care Unit (MCFH) and were not utilized for the benefit of HIV/AIDS clients.**

The Department of Health (DOH), Bureau of HIV/AIDS Care personnel perform certain functions and duties which directly benefit the Department of Social Services' (DOSS) Medicaid program. DOSS reimburses DOH in accordance with the AIDS Waiver program. These monies represent a repayment to DOH for their bureau funds expended to support DOSS. Therefore, these funds should be spent for the direct benefit of the Bureau of HIV/AIDS Care. All reimbursement monies were deposited directly into the divisional account of the Maternal, Child and Family Health Care (MCFH) until July 1997 and used solely to benefit the MCFH, rather than the Bureau of HIV/AIDS Care. During FY 96 & FY 97, funds in the amount of $70,242 and $61,231, respectively, were deposited into the MCFH division account. Personnel within the Bureau of HIV/AIDS Care reported they were unaware of the availability of Medicaid reimbursement monies and, therefore, had not spent any of these funds. Since July 1997, these reimbursement monies have been deposited into a separate account within the Bureau of HIV/AIDS Care; however, as of January 7, 1998, none of these funds had been expended.

Bureau and federal funds are used to benefit the Medicaid Program; therefore, the reimbursement of these expenditures should be directly benefiting the DOH, Bureau of HIV/AIDS Care.

RECOMMENDATION TO FINDING #4

Oversight recommends that the Bureau of HIV/AIDS Care take steps to maximize all funding sources to benefit HIV/AIDS clients. Oversight further recommends that the Senate Appropriations and House Budget Committees consider the Medicaid reimbursements in future budgetary decisions.

Agency Response to Finding #4

Department of Health:

MDOH disagrees with this finding. The $130,000 Medicaid credit referred to in this finding was deposited back into the account from which the original payment was made.

This finding is based on an unclear Oversight assumption that "Bureau and federal funds are used to benefit the Medicaid Program; therefore, the reimbursement of the expenditures should be directly benefiting the DOH, Bureau of HIV/AIDS Care". In 1995 over $1.55 million in additional clients services were funded from department wide cuts in personnel, travel, expenses and equipment over a period of several months. All bureaus and programs within the department made great sacrifices to assure that these additional client services were provided. No Bureau dollars, either federal or state, were utilized to provide these services. Therefore, the $130,000 referred to in this finding is a credit from Medicaid for services rendered during this time period that should have been paid by Medicaid and was appropriately deposited back into the account from which the original payment was made.

Oversight Division's Comment to Finding #4

During fieldwork interviews, Bureau administrative employees stated that Medicaid funds were not available for program expenditures during the time period reviewed.

FINDING #5:	**The Department of Health (DOH), Bureau of HIV/AIDS Care has utilized a private benefit administrator to administer the Aids Drug Assistance Program (ADAP), resulting in additional administrative costs.**

The Department of Health (DOH) currently pays Healthcare Strategic Initiatives (HSI), the statewide benefit administrator for the Ryan White Title II and ADAP funds, an 8% fee for the administration of the medications program. The monthly average wholesale price of protease inhibitors for one client is $1,046. Therefore, based upon HSI's 8% fee, the monthly fee per client paid to HSI for the medications could be as much as $84. Missouri has 132 slots being utilized for protease inhibitors, which could result in HSI receiving up to $132,548 annually for this function. Oversight checked with a pharmacy management company and determined they charge $.75 per paid prescription. Therefore, based on a potential for three prescriptions to be filled per client per month, the total cost per client for a pharmacy management company administering the medications program would be $2.25 per month, resulting in an annual cost of $3,564 for 132 slots. There could be an annual difference of up to $128,984 between what the DOH is reimbursing HSI versus a pharmacy management company for administering the medications program.

HSI keeps track of patient contacts and authorizations for medications through a point of service numeric authorization process and providers are paid based on service delivered (i.e., fee for service). Approximately 90% of medications are recurring with very few emergency situations requiring authorization. However, HSI can provide verbal authorizations 24 hours a day. In order to be reimbursed, pharmacies must manually complete a Health Care Financing Administration (HCFA) Form 1500. Many pharmacies are currently computer linked with a pharmacy management company, while HSI is not, making the authorization and reimbursement processes laborious, according to pharmacies contacted.

Oversight contacted a pharmacy management company with specialized pharmacy networks designed to offer competitive pricing and high levels of performance, with 35,000 pharmacies on-line and approximately 360 of them located within Missouri. There are approximately 70 pharmacy management companies nationwide. The administrative cost for the company contacted is $.75 per paid claim. Participating pharmacies must

meet certain standards to get into and remain in the network. Prior authorization is an administrative tool used to enhance quality and reduce cost by insuring appropriate utilization of specific drugs. Once an authorization form is completed, the pharmacy would have the ability to submit prescription information through the computer system. Member eligibility verification, claims adjudication, billing and management reporting would be accomplished by electronic means as well.

Alternative means of administering the medications program could reduce the administrative cost, as well as increase the efficiency of the program by automating more functions (i.e., eligibility verification, billing, reporting, etc.). A reduction in administrative costs could conceivably increase the funds available for additional medications.

RECOMMENDATION TO FINDING #5

Oversight recommends the Department of Health (DOH), Bureau of HIV/AIDS Care consider utilizing a pharmacy management company to administer the ADAP in order to make funds available for the purchase of additional drugs for clients.

Agency Response to Finding #5

Department of Health:

This finding is the same as finding #2 and again we disagree. The program review attempts to portray this as a different finding and substantiate it by raising bidding, protease slot and pharmacy issues. The Oversight pharmacy recommendation would actually cost the state as much as $300,000 more a year than the current department pharmacy program. Also, this finding contradicts finding #9. As we have already explained to Oversight staff:

a. *DOH went out on competitive bid for the administration of the Ryan White Title II and ADAP programs in FY97. Over twenty agencies were notified of the bid process, as well as public advertisements. HSI was awarded the contract based on this open, competitive bid process.*

b. *As was discussed in the Agency Response to Finding #3, any agency contracting to perform such complex services must charge a certain administrative fee. The Ryan White CARE Act allows grantees to pay*

contractors up to ten percent in administrative costs for contractors, HSI charges eight.

c. *The ADAP program eliminated the 132 protease inhibitor "slots" mentioned in this finding during the first weeks of the Oversight review.*

d. *The pharmacy management company recommended by the Oversight review collects a per-prescription fee only for filling and delivering the prescription. This does not include enrollment of clients, collection and reporting of client-level enrollment information, the prior authorization of medications as well as other Ryan White program services, the coordination of Ryan White and ADAP services, the repeated checking of Medicaid eligibility, working with and providing service utilization data to local consortia, developing and enrolling local providers, and the enormous amount of reporting required by the ADAP benefits administrator. This comparison is completely unfounded.*

e. *The pharmacy management company recommended by the program review would actually cost the state at least an additional $300,000 because in addition to a seventy-five cent prescription charge the company keeps all manufacturer rebates. Therefore, this finding contradicts finding #9.*

Oversight Division's Comment to Finding #5

Although DOH awarded the statewide benefit administrator contract through a competitive bid process, only three bids were received and two were deemed nonresponsive by DOH. Furthermore, it is Oversight's understanding that contracting with a pharmacy management company would not preclude DOH's receipt of pharmacy rebates. Based on Oversight's research, receipt of rebates would be dependent upon contract provisions.

FINDING #6:	**The Department of Health issued an advance payment in the amount of $379,655 to Healthcare Strategic Initiatives, L.L.C. which was not authorized in the contract.**

The Department of Health (DOH) issued a 10% contract advance payment in the amount of $379,655 to Healthcare Strategic Initiatives, L.L.C. (HSI) without the contractual authority to do so. HSI personnel requested the $379,655 cash advance payment on March 28, 1997, which was prior to the contract being awarded to HSI. The contract was not awarded to HSI until March 31, 1997. HSI later invoiced DOH for the $379,655 advance request on April 4, 1997, citing ".... This advance is being requested pursuant to the comments submitted by the Review Committee and the Department." However, it should be noted that the Review Committee Minutes did not contain any comments relating to an advance payment. A Management Analyst I approved the contract advance request on April 8, 1997, and an Internal Warrant Request was issued on April 9, 1997, processing the advance payment. DOH personnel reported the contract advance was made pursuant to the benefit administrator contract. However, the contract does not authorize the payment of a cash advance and, in fact, states all payments are to be made on a cost reimbursement basis.

Section 3.6 of the Invitation for Bid (IFB# 7036) requires HSI to "submit timely invoices to the Department that meet the requirements of this contract for the reimbursement of program expenditures" (emphasis added). DOH's Division of Administration also confirmed that the contract with HSI is intended to be a cost reimbursement contract only.

The Management Analyst I provided a copy of a document entitled "Scope of Work" drafted months after the advance payment was issued to HSI, which appears to allow a 10% advance payment. However, the contract was never amended to incorporate this new "Scope of Work." Furthermore, even if the contract had made provision for a 10% advance, the request for an advance was made prior to the issuance of the contract.

RECOMMENDATION TO FINDING #6

Oversight recommends that the Department of Health (DOH) make arrangements to recoup the $379,655 cash advance payment from HSI and ensure that contract provisions are adhered to in the future.

Agency Response to Finding #6

Department of Health:

DOH previously identified and corrected this issues as follows:

HSI has a goal of paying providers within 7 days. DOH's turnaround to the contractor may be 30+ days. DOH's Accounts payable unit matches invoices to a contract or other purchasing authority but does not verify compliance with contract provisions. HSI had received advances in prior years. Thus, Payables had no reason at the time to question the payment request. The fact that HSI prepared an invoice prior to the contract start date is not relevant. The contract was in place before the invoice was approved and paid. Accounts payable has been instructed to verify recoupment of the advance on subsequent HSI invoices. DOH will review the justification for an advance.

FINDING #7:	**The Department of Health - Bureau of HIV/AIDS Care lacks adequate control over employee expense reports.**

Oversight staff noted certain questionable transactions involving reimbursement of employee expense reports:

* The Assistant Bureau Chief filed twelve monthly expense reports all at one time, totaling $2,808.13. A subordinate employee (Management Analyst I) authorized the reimbursement of these expense reports by signing the Bureau Chief's name to all twelve reports, only two days after the new Bureau Chief began employment and apparently without the Bureau Chief's knowledge. Oversight questions whether the Management Analyst had the authority to approve the expense reports of the Assistant Bureau Chief.

* One instance was noted in which an employee was reimbursed for expenses without an approval signature. The employee had written in "Chief, BHAC" and the date, but there was no approval signature. We also noted an instance where an employee was reimbursed $48 for phone calls to the office (on one day only) without documentation.

* Some employees have received mileage reimbursement nearly every day of the month without proper documentation. For example, there were office records with no signatures, no arrival times, no departure times, and no documentation of the purpose or destination for such mileage reimbursement. In fact, there were instances where the supervisor who approved the reimbursement had noted on actual expense reports that no documentation existed, yet the employees were still reimbursed for these purported expenses.

* Numerous instances were noted where employees were reimbursed for lunch when their logged out departure time was after noon. We requested copies of the travel logs from one office and learned that all but four months of these logs during the prior three year time period had been destroyed.

The Department of Health - Bureau of HIV/AIDS Care has adopted the ***Office of Administration Travel Regulations*** and should be closely following these standards. DOH personnel reported they assume the expenses have been verified when the supervisor signs the expense reports. Rule 16(c)(5) states that "Primary responsibility for authenticating travel reimbursement claims rests with the department and agency directors." Therefore, it is crucial for supervisors to realize the importance of their approval signature on the expense reports and to verify the expenses being claimed and approved have actually occurred. For example, employees should not be reimbursed for lunch when their travel did not begin until after noon. Also, it is prudent for all offices to maintain copies of the travel logs for review and verification. Furthermore, employees should be encouraged to file timely expense reports. It is not advisable to file twelve months of reports all at one time, as it is difficult to verify the expenses being reported and is also contrary to OA Guidelines. Finally, it is imperative that proper approval be required for all expense reports. The Assistant Bureau Chief's expense reports should be approved by the Bureau Chief or another supervisory employee, rather than a subordinate employee.

A lack of control and specific guidelines relating to the filing of expense reports has allowed employees to file expense reports without proper documentation and approval. Also, travel logs have been destroyed, leaving no documentation to support certain mileage reimbursements. Finally, improper approval signatures cast doubt upon the propriety of expense reimbursements.

RECOMMENDATION TO FINDING #7

Oversight recommends that the Department of Health, Bureau of HIV/AIDS Care establish guidelines to ensure that expenses being reimbursed are proper, timely, and meet the guidelines established for reimbursement. Due to the travel requirements within this Bureau, DOH should consider implementing guidelines which would require employees to maintain precise travel records.

Agency Response to Finding #7

Department of Health:

This issue was previously identified and corrected by Bureau management. Clarification on allowable travel and meal costs was distributed to all Bureau staff on November 3, 1997.

FINDING #8:	**The Department of Health (DOH), Bureau of HIV/AIDS Care did not regularly monitor its professional services contracts to ensure provision and quality of services to HIV/AIDS clients and to verify existence and/or appropriateness of expenditures.**

The DOH did not monitor its professional services contracts during PY 96 in accordance with its administrative manual. A contract monitoring schedule was developed in September 1997, but some of those visits have been rescheduled and no reports have been issued. However, a partial report resulting from a DOH monitoring visit during September 1997 to the Kansas City Health Department revealed overpayments of $47,000, due to Kansas City's failure to check Medicaid eligibility. Furthermore, if routine monitoring had been conducted, it is possible that over payments to the Ryan White Title II benefit administrator could have been detected by DOH. Therefore, potential for further discrepancies is possible and may have gone undetected without regular monitoring.

Section 22.4 of the Department of Health (DOH) administrative manual outlines contract monitoring procedures consisting of financial, programmatic and general provision compliance and requires at least two site visits on each contract - one visit before half of the contract period has

lapsed and a second visit within 45 days after the contract ending date. The financial compliance portion requires desk audits of invoices with the final determinant of financial compliance being an independent audit. Programmatic compliance entails receiving periodic reports and comparing them with contractual requirements and site visits to sample contractor records to verify the provision and quality of service. General provision compliance pertains to the standard clauses such as civil rights compliance. For any discrepancies noted during a visit, corrective or administrative action is admissible, including such actions as withholding payments, terminating contracts, not renewing contracts, recommending vendor debarment or initiating legal action.

Apparently, the DOH made some informal "fact finding" visits during PY 96, but no formal monitoring was done of Ryan White Title II expenditures. The DOH personnel indicated they completed desk audits for PY 1995 contracts in July 1997, but a review of the files only revealed two such audits. A contract monitoring schedule was developed in September 1997 to perform various closing and in-progress visits for different programs including, GR housing, service coordination, Ryan White Title II, ADAP and HOPWA. Five of the original twenty-six monitoring visits scheduled have been rescheduled, while eleven have been completed, but reports are still pending. Fourteen out of eighteen (78%) of the closing monitoring visits have not been completed within 45 days after the contract ending date. As of November 24, 1997, the statewide benefit administrator for the Ryan White Title II and ADAP funds (HSI) had not been monitored.

The Department of Health (DOH), Bureau of HIV/AIDS Care cannot ensure the provision and quality of services and financial accountability to HIV/AIDS clients without monitoring contractual obligations, including the monitoring of the subcontractors/providers.

RECOMMENDATION TO FINDING #8

Oversight recommends the Department of Health (DOH), Bureau of HIV/AIDS Care monitor its professional services contracts in accordance with its own policies and procedures.

Agency Response to Finding #8

Department of Health:

This finding is incorrect as follows:

a. *Bureau staff made at least one monitoring visit to each Ryan White and HOPWA contractor during PY96.*

b. *All contractors have been monitored once during PY97, with closing reports done on PY96 contacts and in-progress reports on FY97 contacts either finalized or being finalized. In fact, as the report indicates, the visit to the Kansas City Health Department resulted in a finding of contractor non-compliance resulting in approximately $47,000 worth of Medicaid recoupment.*

c. *The monitoring process has been strengthened by the outsourcing service coordination, which allowed the shifting of responsibilities of the district staff from service coordination supervision to quality assurance and ongoing monitoring of contractors and subcontractors. Therefore, this finding is in conflict with finding #3.*

d. *The Bureau is currently in the process of hiring two program managers and one additional fiscal staff person who will all work very closely with program contacts and monitoring.*

Oversight Division's Comment to Finding #8

Oversight staff requested, but was not provided with PY 96 Ryan White Title II monitoring reports.

FINDING #9:	**The Department of Health (DOH), Bureau of HIV/AIDS Care has not aggressively pursued pharmaceutical rebates for HIV/AIDS drugs.**

The Department of Health (DOH), Bureau of HIV/AIDS Care has pharmaceutical rebate agreements with Glaxo-Wellcome and Merck & Company Incorporated. The Glaxo-Wellcome rebate program originated with Burroughs-Wellcome in 1993 and was an informal arrangement with

the states in which a rebate equivalent to the Medicaid program rebate was given. Missouri received approximately $43,000 in 1993; $39,000 in 1994; an indeterminate amount in 1995; and none in 1996. The merger between Burroughs-Wellcome and Glaxo resulted in a more formalized rebate program with written contractual agreements effective April 1, 1997, as initiated by the company. As of November 1997, the DOH has received $23,000 in rebates for program year 97 under the new agreement from Glaxo-Wellcome with the potential for additional rebates from newly approved and anticipated release of drugs.

Merck initiated a nationwide rebate program to coincide with the launch of the drug Crixivan in 1996. The rebate program was presented to DOH in early 1996, with no action taken by DOH until sometime in December, 1996. The original offer would have expired in December, 1996, but Merck was willing to extend the agreement. A finalized agreement was not signed between Merck and the DOH until September, 1997. It appears that the DOH would have been able to receive rebates in 1996 had an agreement been finalized earlier. The DOH will be eligible to receive rebates for the third quarter 1997 (i.e., July 1, 1997 - September 30, 1997) if the appropriate documentation is submitted to Merck within the established time frames.

According to a report issued by the National Alliance of State and Territorial AIDS Directors, there are ten pharmaceutical companies currently offering rebates to states including Glaxo-Wellcome, Merck & Company, Bristol Myers Squibb, Abbott, Hoffman-LaRoche, Pfizer, Fujisawa, Jacobus, Pharmacia & Upjohn and Roerig. The DOH has had no contact with eight of the ten companies.

RECOMMENDATION TO FINDING #9

Oversight recommends the Department of Health (DOH), Bureau of HIV/AIDS Care aggressively pursue pharmaceutical rebates, allowing the department to maximize the use of their resources in the purchase of medications for HIV/AIDS clients. Oversight further recommends that the Senate Appropriations and House Budget Committees consider the rebates in future budget decisions.

Agency Response to Finding #9

Department of Health:

DOH supports the utilization of pharmaceutical rebates and agrees that the Bureau has not "aggressively" pursued these rebates. The DOH has pursued these rebates in a fiscally accountable manner. Pharmaceutical rebates are achieved through the signing of legally binding contracts between the DOH and the pharmaceutical company. It would be fiscally irresponsible and place the state at legal liability to sign a pharmaceutical rebate agreement without first assuring that DOH is not assuming any form of product liability. The Bureau has two rebates in place which have generated over $250,000. Two more are under legal review.

Oversight Division's Comment to Finding #9

As of November, 1997, information provided to Oversight indicated only $23,000 in rebates had been received by DOH for 1997.

FINDING #10:	**The benefit administrator contract does not require subcontracts to be competitively bid to ensure that the "best price" is obtained for HIV/AIDS medications and services.**

Currently the DOH has agreements with certain pharmacies in order to provide the necessary medications to individuals at a discounted price. The current contracts in the Kansas City area with Statscript Pharmacy, Country Club Pharmacy, Truman Medical Center and Kansas University Medical Center were originally negotiated by the Kansas City Department of Health. The price per script varies for each of the four pharmacies. When Healthcare Strategic Initiatives (HSI) became the benefit administrator, an agreement was reached whereby the existing contracts would still be valid with HSI.

In the outstate area, the price per script is the average wholesale price minus 5%. This was the price being paid by the Ryan White Title II Program when HSI became the benefit administrator.

A local pharmacy was contacted in order to obtain the average wholesale price for three protease inhibitors: Invirase - $572.06 per 270; Epivir -

$230.41 per 60; and Zerit - $243.52 per 60. This would be the combination of protease inhibitors for one person for one month at a total cost of $1,046 per month.

The following summarizes the discounts, dispensing fees and estimated annual costs for a three-drug combination of protease inhibitors for the existing 132 slots. This would be the maximum cost paid per pharmacy if all 132 slots were filled by one pharmacy. (Note: The following prices do not include the 8% administrative fee paid to the benefit administrator.)

Pharmacy	Discount	Dispensing Fee	Annual Cost
Country Club Pharmacy	14%	$8.39	$1,464,091.20
Statscript Pharmacy	8%	$0	$1,523,602.08
KU Medical Center	11%	$0	$1,498,852.08
Truman Medical	19%	$2	$1,350,922.32
Outstate	5%	$0	$1,573,276.32

Based on the various discounts offered and dispensing fees charged by the pharmacies, annual costs could vary by $200,000 or more for the purchase of these drugs.

Even though HSI is currently working on a request for proposal (RFP) to competitively bid subcontracts, the primary contract does not require such action.

The Department of Health (DOH), Bureau of HIV/AIDS Care cannot ensure that the "best price" is being received for medications and services without competitively bidding subcontracts. Ensuring that the best price is received could conceivably result in the purchase of additional medications and services for HIV/AIDS clients.

RECOMMENDATION TO FINDING #10

Oversight recommends the Department of Health (DOH), Bureau of HIV/AIDS Care write any future contract(s) to require that subcontracts be competitively bid in order to ensure that the "best price" is received for medications and services.

Agency Response to Finding #10

Department of Health:

This finding is incorrect and erroneous in its assumption that requiring competitive bidding of all subcontracts is the only way to assure "best price".

a. *The current benefits administration contact is under a first year review and the new contract will require the contractors to obtain a "best local price" that is comparable throughout the state which will reduce costs but still allow clients to choose from participating local pharmacies.*

b. *The possibility or requiring the benefit administrator to obtain a "best price" purchasing arrangement was discussed with local consortia representatives and at the IFB (initiation for bid) review meeting. The benefit administrator already offers a discounted mail-order pharmacy in all areas of the state. Bureau staff explored the possibility of using the mail-order pharmacy exclusively and the overwhelming response from the communities was to continue to offer clients local pharmacy choice.*

c. *Members of the community explained that it is often the local pharmacist who has the most contact with the client, who explains to the client how to take the drugs and the importance of adherence to the drug regimen, and who can often best monitor the client's compliance. This relationship is invaluable to HIV/AIDS patients, as non-compliance or misuse of medications can result in the development of a new, more deadly drug-resistant strain of the HIV virus.*

d. *Several methodologies used by Oversight staff are flawed: (1) HIV+ persons are not typically on a combination of three protease inhibitors. Rather, standard combination therapy consists of one or two protease inhibitors and one or two anti-retrovirals. (2) The 132 protease inhibitor "slots" used in projecting costs were eliminated more than six months ago. (3) It is not explained how the local pharmacy price relates to the Kansas City pharmacy prices in the comparison or how the "outstate" price was obtained.*

FINDING #II:	**The Department of Health (DOH), Bureau of HIV/AIDS Care, did not process invoices for payment within the 45 day time limit required in Section 34.055.**

It is the Department of Health (DOH), Bureau of HIV/AIDS Care's policy that upon receipt of an invoice, it will be processed within 48 hours and sent to the Division of Administration. The Division of Administration generally has a two-week turnaround period for payment of invoices. A sample of Housing Opportunities for Persons with Aids (HOPWA) invoices from July, 1996 through October, 1997 was reviewed to determine the length of time to process payment.

Section 34.055 requires the payment of interest charges or late payment charges, except as provided in section 34.057, after the 45th day following the later of the date of delivery of the supplies and services or the date upon which the invoice is duly approved and processed. The interest would be retroactive to the 30th day on any unpaid balance except for specific services as provided by statute. A sampling of invoices revealed seven invoices totaling over $52,000 were paid after the 45 day limit. They ranged up to 64 days in processing time. However, according to the Division of Administration, the department has never paid any interest due to late payments.

The Department of Health (DOH), Bureau of HIV/AIDS Care does not track how long it takes to process an invoice once it is approved and sent to the Division of Administration for payment. The only time the Bureau is aware of how long it takes to process an invoice is when the SAM reports are issued or if a contractor calls with a question.

The delay in payment of invoices could result in the program expending funds to pay interest charges incurred.

RECOMMENDATION TO FINDING #II

Oversight recommends the Department of Health (DOH), Bureau of HIV/AIDS Care develop a tracking mechanism and ensure that invoices are processed within the 45 day limit in accordance with Section 34.055.

Agency Response to Finding #11

Department of Health:

Bureau management previously identified and corrected this issue. Beginning with the award of the third party administrator contract in October, 1997, the invoices are processed in less than one week.

In fact this is another example of where privatizing these administrative functions is desirable over building redundant capacity within the Department. The system for processing invoices is as follows: Section 34.055, RSMo, prohibits payment of interest charges for late payments without "application of the vendor thereof". In other words, we cannot make a late payment charge without a separate billing from the vendor. Also, a state agency is under no obligation to inform the vendor of their legal right to bill for late charges. Also, a potential interest obligation would begin to accrue after the invoice is "duly approved and processed". Thus, a program could withhold approval of an invoice for valid reasons without incurring a potential liability for interest.

FINDING #12:	**Services to the HIV/AIDS clients statewide may be inconsistent because of a lack of understanding regarding responsibilities of service coordinators.**

The Department of Health (DOH), Bureau of HIV/AIDS Care does not have a current service coordination manual establishing standards/guidelines for service coordinators in providing services to HIV/AIDS clients. In its service coordination contracts, the Department of Health (DOH), Bureau of HIV/AIDS Care references a Service Coordination Manual which has not been updated since 1989. The service coordination manuals for Cole County, Boone County, and St. Louis were reviewed by Oversight staff. The manuals varied among the locations and were different from the manual provided to Oversight by the DOH Central Office. The DOH personnel indicated they have formed a review team for the purpose of updating the manual. According to DOH personnel, time constraints have prohibited the review team from meeting and updating the service coordination manual that would provide guidance to service coordinators regarding their responsibilities and functions.

Interviews were conducted with various personnel, including service coordinators. The service coordinators had different and varying ideas of what their responsibilities were to HIV/AIDS clients. Examples of differences included checking Medicaid eligibility, verifying income, establishing residency, authorizing 24 hour care, conducting outreach, determining annual caps and funding sources, and accessing all available services (i.e., community resources in conjunction with Ryan White services).

A report prepared for the Metropolitan St. Louis AIDS Program by Daniel Gentry, PhD, MHA, St. Louis University School of Public Health, Susan Lehrman, PhD, MPH, Union College Graduate Management Institute and special assistance from Emily Gantz McKay, MA, MOSACIA - The Center for Nonprofit Development and Pluralism, addressed the need for service coordination standards. It was concluded that service coordination standards would improve the consistency and quality of service across the system; provide specific expectations for monitoring and evaluation purposes; increase communication and coordination, thus, lessening duplication; and enhance the ability to measure communication, coordination and duplication across the system.

The out-of-date service coordination manual was a finding in a DOH internal audit report issued in September 1995. In a follow up review in June 1996, DOH staff indicated the manual was under revision and the draft was due to be completed on May 30, 1996.

The Department of Health (DOH), Bureau of HIV/AIDS Care may not be able to ensure that provision and quality of service is consistent statewide, since the service coordinators do not have a clear understanding of their responsibilities and functions. Lack of an official, updated service coordination manual could result in inconsistent services among contractors. Furthermore, the lack of established standards/guidelines makes monitoring and evaluation of the service coordination function difficult.

RECOMMENDATION TO FINDING #12

Oversight recommends the Department of Health (DOH), Bureau of HIV/AIDS Care update its service coordination manual, establishing standards/guidelines for the quality and provision of care for HIV/AIDS clients and disseminate the new manual to service coordinators to ensure consistency of services and allow for effective monitoring and evaluation.

Agency Response to Finding #12

Department of Health:

Bureau Management identified the strengthening of the statewide HIV/AIDS service coordination system as a priority in July 1997 and has taken the following steps to achieve this goal:

a. *As a part of the outsourcing process, the roles and responsibilities of the three District staff were shifted from "service coordination supervision" to "quality service management" (quality assurance) functions. These staff have been working closely with service coordination contractors: (1) to ensure that appropriate quality of care standards are maintained; (2) to ensure contractor/subcontractor compliance with program policies, guidelines, and procedures; and (3) to provide technical assistance to contractors and service coordination staff.*

b. *Bureau staff have worked with teams in St. Louis and Kansas City to develop service coordination manuals for those local health departments. Much of that information, along with revisions resulting from outsourcing, will be incorporated into the revised DOH service coordination manual scheduled to be completed by the end of 1998.*

FINDING #13:	**The Department of Health (DOH), Bureau of HIV/AIDS Care is not maximizing its use of staff resources.**

Resources from the Ryan White funds for staffing purposes should be used to achieve maximum benefit for the program to serve HIV/AIDS clients. Formal job expectations and specific goals should be developed prior to hiring staff to help ensure the staff resources expended provide for administration of a comprehensive program to serve HIV/AIDS clients.

In July 1997, the DOH, Bureau of HIV/AIDS Care employed a Medical Doctor at an annual salary of approximately $90,000 to fill a newly created position of Medical Consultant. Based on discussions with DOH staff, Oversight concluded there is no specific direction defined for this newly created position. The service coordinators were aware of the new position,

but could not specify any instances of particular assistance they or their clients had achieved as a result of this new position.

The services provided by such a high level staff person could either be contracted out or the Bureau of HIV/AIDS Care could draw upon existing DOH resources and expertise to perform functions the Medical Consultant is now providing, thus reducing and/or redirecting staffing costs. DOH could utilize funds saved from such action to provide additional monitoring and oversight of the program.

RECOMMENDATION TO FINDING #13

Oversight recommends DOH, Bureau of HIV/AIDS Care consider restructuring its staff to maximize use of personal service resources to achieve the greatest benefit to serve HIV/AIDS clients. Oversight further recommends the Senate Appropriations and House Budget Committees consider staff composition of the Bureau in future budgetary decisions.

Agency Response to Finding #13

Department of Health:

This finding is not substantiated with fact. Maximal utilization of staff resources includes the development of appropriate roles and responsibilities, oversight, efficient practices and the assurance that critical professional expertise is available, as dictated by the program or function in question.

a. *The Bureau Nurse Consultant retired and was replaced by a Medical (physician) Consultant. The Nurse Consultant supervised the state service coordinators who have been outsourced. The role of supervisor was no longer required. The Medical Consultant fulfills a completely different and critical role. Clients take as many as twenty-five medications a day. The complexities and side effects of these drug regimes challenge physicians, nurses, and pharmacists daily and affect their ability to practice in the area of HIV infectious disease.*

b. *The Medical Consultant position is a highly, valuable asset to the programs and the clients. The education of clients, physicians, and pharmacists is critical in being able to ensure compliance with drug regimens in order to avoid drug-resistant strains of the virus. A major role of this position will be such education, ensuring that physicians*

are prescribing "optimal" medications therapy and ensuring that clients adhere to prescribed regimens. Another key component of the Medical Consultant's role is the collection and analysis of consistent medical, treatment and demographic information of all program clients in order for DOH to have better understanding of the disease and its progress, as well as to measure the success of current treatment strategies.

c *The current Medical Consultant is board certified general practice and is obtaining board certification for infectious disease. She actively practices in an AIDS clinic, in cooperation with an infectious disease physician, one day per week. Her extra commitment to maintain this practice adds invaluable knowledge to the Bureau's program planning and needs assessments.*

d. *HRSA has commended the DOH for being a leader in identifying the medications issues and addressing them through several areas including the hiring of a Medical Consultant.*

e. *The statewide coordinated assessment of need process identifies physician technical support as a critical issue for rural Missouri.*

Oversight Division's Comment to Finding #13

Based upon personal interviews with the Medical Consultant herself, DOH staff and service coordinators, it appears they do not understand the role as described in DOH's above response.

FINDING #14:	**The Department of Health (DOH), Bureau of HIV/AIDS Care did not begin the contract process in sufficient time to allow finalized contracts to be received by contractors prior to the beginning of the contract period.**

The contract tracking logs for the service coordination, benefit administrator and Housing Opportunities for People with Aids (HOPWA) were obtained for program years (PY) 96 and 97.

The analysis of the timing of critical events in the contract process illustrated the necessity of beginning the process sooner to allow for completion of the steps necessary to finalize contracts prior to the beginning of the contract period. The contract process includes development of a scope of work for each contract. After the scope of work section is incorporated into the contract and is approved by DOH, the contract is mailed to the contractor for signature. The contractor submits a signed copy to DOH for further processing to be finalized with appropriate signatures. Finally, the signed contract is sent to the contractor.

Oversight staff reviewed the time period between when the scope of work was prepared or finalized and when the contract period began. The scope of work for the PY 96 benefit administrator contract for one contractor was completed 115 days past the beginning of the contract period. For PY 97, the scope of work for one service coordination contract was completed 38 days past the beginning of the contract period. Also, the scope of work for the PY 97 statewide HOPWA contract for the benefit administrator function was prepared October 1, 1997, the day on which the contract period began. DOH had to rely on the previous contractors for continuation of service into the next contract period, because the new contract was not finalized. Additionally, there were instances where a DOH employee drove a contract to an out-of-town contractor to ensure the contractor received a signed copy of the contract prior to the beginning of the contract period.

The delay in finalizing contracts prior to the beginning of the contract period could conceivably affect the provision of services to HIV/AIDS clients. The Division of Administration assumes that a contract is effective with the beginning of the contract period. However, if a contract has not been signed by all parties involved, it appears that contractors may not be required to provide services nor would the DOH be required to reimburse the contractor for any services provided.

RECOMMENDATION TO FINDING #14

Oversight recommends the Department of Health (DOH), Bureau of HIV/AIDS Care take steps to ensure the timely writing and finalizing of contracts to avoid gaps in contracted periods and the legal ramifications which might be associated.

Agency Response to Finding #14

Department of Health:

This finding is misleading and the substantive issues surrounding it have already been corrected by Bureau management.

a. *The statutory and regulatory requirements for state agencies to bid contacts take a considerable amount of time for processing. A case in point is the HOPWA contact that is identified in the program review finding. The scope of work for this contract was completed in January 1997 for a contract beginning July 1, 1997. It appeared this was sufficient lead time for review, modifications, and approvals, as well as, the actual bid process and evaluation however, the contract was not signed until October 1, 1997.*

b. *The scopes of work for the SFY99 statewide Ryan White, ADAP, and HOPWA benefits administrator and service coordination contracts have already been written, in October 1997, and submitted to OA Purchasing to process the bid.*

c. *The Oversight program review comment that DOH "assumes" that a contract is in effect on the contract start date is incorrect. By DOH policy and contract law, a contract is not effective until it is signed by all parties.*